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COMPARISON OF PSYCHOSOMATIC SYMPTOMS AND SEXUAL TENDENCY IN WOMEN WITH A HISTORY OF MENTAL DISORDERS, WOMEN WITH PHYSICAL ILLNESS AND HEALTHY WOMEN IN TEHRAN PROVINCE, IRAN

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Abstract:
This study compares psychological symptoms and sexual tendencies in women with a history of mental disorders, women with physical and health problems. This research is a methodological, descriptive, and causal comparison, in terms of the fundamental purpose and in terms of collecting data in a field type. The statistical population of this study consisted of women with a history of mental disorders, having a physical and health condition in the year 95. In order to select a sample in this study, 30 samples from each of the women's communities were selected and 90 subjects were selected as research samples. The method of sampling in this research was targeted to healthy people, randomized and available for people with a history of mental disorders and physical illness. According to the research goals and types of variables, a tool was used to measure the variables. Based on library studies and web searches, the psychotic symptoms questionnaire (Takata & Washakata, the Holbert) Sexuality Scale and (OBQ-44) questionnaire were selected as the research tool. In order to distribute the questionnaires, the relevant clinics were coordinated, the questionnaires were distributed among the research samples, and the questionnaires were completed after the response. In order to test the statistical hypotheses after confirmation of the default, the normal distribution of data was done using one-way ANOVA tests and post-Tukey and T-test dance tests for comparing psychosomatic symptoms and sexual tendencies among the research samples. The results of the test of statistical hypotheses showed that psychological symptoms and sexual orientation in women with a history of mental

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disorders, women with physical illnesses and healthy women have a significant difference.

Keywords: psychosomatic symptoms, sexual orientation, mental disorders

1. Statement of the problem

Obsessive beliefs are one of a kind of anxiety disorders that has been widely known over the years. The average age of onset of this disorder is usually about 20 years. Clinical obsessive-compulsive disorder involves complex thinking, disturbing thoughts and difficult clinical behaviors. It is a solid one that interferes with the person's life and causes his discomfort (Izadi, 2012). This disorder is sometimes described as obsessive-compulsive disorder; the obsessive thought (obsessive belief) includes thoughts, impulses, disturbing thoughts and feelings that disturb the person. It seems that the person has to It is about thinking about things that it always wishes to not be able to think about (Sadeghi et al., 2011). Sometimes these obsessive beliefs are manifested in action, which is called obsessive action (compulsion), in which a person is forced to perform anxiety in order to reduce his anxiety during the onset of his obsessive thoughts. The presence of compulsive thoughts and behaviors Together, it is different in people with this disorder (Izadi, 2012). The origin of obsessive-compulsive beliefs can be negative thoughts and evaluations of the patient. When obsessive-compulsive thoughts go into compulsive action, one in his mind strengthens these negative thoughts and, with his misleading assessments, sees himself as ill for the resolution of these thoughts. The intruder must take action and in fact the person feels that he intends to do that (Izadi, 2012).

What is noteworthy is that obsessive beliefs can lead to abnormalities in the body, which are referred to as mental disorders. Mental disorders are physical illnesses that occur after severe stresses and include biochemical, anatomical or physiological disorders (Izadi, 2012). The factors causing obsessive beliefs that can lead to psychotic symptoms of their kind include socio-cultural factors and weaknesses in social interactions, such as job loss, marital links, conflict and conflict, immigration, sexual dysfunction and ..... can be mentioned (Dehghani, 2002). According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), no classification for psychiatric patients is included (Grande et al., 2004). Mental symptoms include migraine, hypertension and stomach ulcers, chronic colitis (colitis), respiratory diseases such as asthma, spinal cord pain and psychosomatic reflux, endocrine disrupting and

nutritional disorders, anxiety Sexual (sexual disorders), etc. (Working Group on cognizing Obsessive Beliefs, 2001). Of this, sexuality is likely to be affected by these disorders. Sexuality blends in such a way with the whole personality of an individual, and even if it is biological, it affects one's self-understanding, relationships with others, patterns of behavior, and self-confidence. That's why talking about sexuality as a phenomenon Independent or biologically impossible (Amini, 2009).

Sexuality as other mental states may be disturbed; the cause of this disorder in women may now be mental-physical and human factors, such as infertility, divorce, abortion or cold. Be. Studies have shown that infertility is one of the factors that affects sexuality and ultimately sexual dissatisfaction, couples who have more sexual desire than one another have a greater sense of happiness, trust, and commitment (Dehghani, 2004). As we said, environmental factors have a lot of influence on sexuality; including these can be called colds in women or women with abortion history. Even healthy women may have been involved in this sexual dysfunction for some time. Being cold is defined as women who have little or no tenderness and tenderness, and who do not. About 10% of these women have a problem with the hormonal system or the pathology of the sex organs. And the problem in 90% of these women is related to emotional issues. On the other hand, women with a history of abortion, whether physically or emotionally and in distress, can also be the cause of sexual dysfunction. Various studies have been conducted on women's disorders. For example, studies on women show that women who are widows or are the heads of household, in addition to severe social and economic deprivation, due to the abjection and acceptance of the new role of the complications Physical and psychological suffering (Riahi, 2009). Unfortunately, in Iran, a research that studies these three disorders among women with a history of abortion, cold-blooded women, and healthy women has not been done. Therefore, the researcher is seeking obsessive-compulsive beliefs, psychotic symptoms and sexual desire in women with abortion history, Cold-blooded women and healthy women compare each other and answer this question in this research: *"Is there a difference between women with a history of psychiatric disorders, psychological symptoms and sexual orientation, women with physical illness and healthy women?"*

2. Theoretical definitions

Psychosomatic symptoms: Psychosomatic symptoms or psychosomatic illnesses are physical conditions that affect psychological factors in their onset and exacerbation. It does not mean that only psychological causes are involved in causing these disorders,

but other factors also interfere with the psychological factors acting as accelerators or catalytic factors (Kaplan, 2011).

Psychosomatic disorders include disorders in which the symptoms are directly related to brain damage or an abnormal situation in the brain's chemical environment; as a result of aging, degenerative diseases (such as syphilis), or poisoning (such as poisoning) From lead or alcoholism) (Koh, 2013).

Psychiatric disorders are disorders that the patient encounters with physical illness due to mental health problems and when he visits a doctor for examination of the disease, the specialist cannot identify any serious physical problems in him and the physical therapy of the disease cannot solve his problems. (Volman, 2012).

Sexual tendency: An evolving process involves biochemical processes and social structures, which are formed at the individual and group levels to create the unique sexual identity of each person (Anderson et al., 2003).

Sexual tendency as an adjective can be defined as the sensitivity of the individual to the sexual stimulus or the individual's context for responding to mental stimulus of sexual anger (Yousefi et al., 2013). Orard and Booth (2001) have suggested sexual desire as a kind of awareness of sexual arousal (Orard & Booth, 2001).

2.1 Operational definitions

Psychiatric Symptoms: The significance of psychiatric symptoms in this study is the score obtained from the psychiatric complaints questionnaire Takata and Sakata (2004). Meanwhile, there are several, continuously variable, symptomatic symptoms that are used in a distance scale.

Sexuality: Sexual orientation in this research is a measure of the score obtained from the Holbert Sexual Excitement Scale. Meanwhile, the sexual tendency is variable, continuously and quantitatively, using a distance scale.

3. Results

Table 1: The status of the normal distribution of data

Variable		Sexual tendency	Psychotic symptoms
Psychiatric disorders	Many	30	30
	Mean	96/2	30/2
	Standard deviation	409/0	472/0
	Z Kolmogorov-Smirnov	120/0	148/0
	Sig	200/0	091/0
Psychiatric disorders	Many	30	30
	Mean	81/2	60/1

	Standard deviation	248/0	164/0
	Z Kolmogorov-Smirnov	213/0	127/0
	Sig	001/0	200
Healthy	Many	30	30
	Mean	16/2	17/3
	Standard deviation	169/0	365/0
	Z Kolmogorov-Smirnov	114/0	087/0
	Sig	200/0	200/0

P <0.05

The results of Table 1 and the Kolmogorov-Smirnov test show that the significance level for sexual tendency tendencies, mental complaints among research samples is more than 0.05, and only the significant level of obsessive beliefs among healthy and cold people and symptoms Psychoanalysis among cold-smokers is less than 0.05. Therefore, with 95% confidence, the distribution of data of variables and components is normal and therefore, parametric tests will be used to test the research hypotheses.

Table 2: Anova Test for Psychosomatic Symptoms

Variable	Group	Mean	Standard deviation	Difference between groups	Difference between groups	F level	Significant level
Psychosomatic Symptoms	Mental disorder	2.30	0.409	7.030	7.477	40.899	0.000
	Physical illness	2.81	0.248				
	Healthy	2.16	0.169				

The results of the test and the level of significance and the amount of F in Table 2 show that there is a significant difference between the psychiatric symptoms among the research groups. Therefore, a follow-up test is used to determine which groups are different. For this reason, we first use the Levine test to determine the homogeneity or non-homogeneity of the variance of the scores.

Table 3: Homogeneity of variance test

Levin's statistics	Df1	Df2	Significance level
6.242	2	87	0.003

According to the Levine test and the significance level below 0.05 (the significance level of the Lone test is less than the significance level (α = 0.05) means heterogeneity of the

variances), the heterogeneity of the variances is confirmed, so the T- Dunn is used as a follow-up test to identify the difference between research groups.

Table 4: T-Dunn's Follow-up Test to Compare Psychosomatic Symptoms among Research Groups

Variable	Groups	Deviation - the difference	Standard deviation	Mean	Significant level
Psychosomatic Symptoms	Mental disorder	-0.511	0.087	2.30	0.001
	Physical illness			2.81	
	Mental disorder	0.138	0.080	2.30	0.252
	Healthy			2.16	
	Physical illness	-0.650	0.054	2.81	.001
	Healthy			2.16	

According to Table 4, there is a significant difference between the mean psychological symptoms of people with physical illness (2.81) and healthy subjects (2.16) with a history of mental disorders (2.30), with regard to their significant level, but between mean Psychotropic symptoms were not significantly different among healthy subjects (2.16) and with history of mental disorders (2.30).

Table 5: Anova's Test for Sexuality

Variable	Group	Mean	Standard deviation	Difference between groups	Difference between groups	F level	Significant level
Sex tendency	Mental disorder	2.96	0.472	7.030	7.477	40.899	0.000
	Physical illness	1.60	0.164				
	Healthy	3.17	0.365				

The results of the test and the level of significance and the amount of F in Table 5 show that there is a significant difference between the sexual tendency among the research groups. Therefore, a follow-up test is used to determine which groups are different. For

this reason, we first use the Levine test to determine the homogeneity or non-homogeneity of the variance of the scores.

Table 6: Homogeneity of variance test

Levin's statistics	Df1	Df2	Significance level
6.463	2	87	0.002

According to the Levine test and the significance level below 0.05 (the significance level of the Lone test is less than the significance level (α = 0.05) means heterogeneity of the variances), the heterogeneity of the variances is confirmed, so the T- Dunn is used as a follow-up test to identify the difference between research groups.

Table 7: T-Dunn's follow-up test to compare sexual desire among research groups

Variable	Groups	Deviation – the difference	Standard deviation	Mean	Significant level
Sex tendency	Mental disorder	1.357	0.91	2.96	0.001
	Physical illness			1.60	
	Mental disorder	0.109	-0.208	2.96	0.172
	Healthy			3.17	
	Physical illness	0.073	-1.565	1.60	0.001
	Healthy			3.17	

According to Table 6, there is a significant difference between the average sexual tendency of people with physical illness (1.60) and healthy individuals (3.7) with a history of mental disorders (2.96), with regard to their significant level, but between mean sexual tendency there was no significant difference between healthy subjects (3.7) and history of mental disorders (2.96).

4. Discussion and Conclusion

In relation to the research hypothesis, it was found that the average rank of psychiatric disorders in women with physical and psychological disorders was different. Meanwhile, the results of post hoc test showed that there was a significant difference between the mean psychosomatic symptoms of people with physical illness and those with a history of mental disorders with respect to their significant level, but there was a significant difference between the mean psychiatric symptoms among healthy subjects There was no significant difference between the history of mental disorders and the results of Makvandi and Heidari (2015), Shafie et al (2013), Asefi et al. (2013) and Lobo

et al. (2015). Psychoanalytic theories first of all consider mental issues that may significantly contribute to the development of physical illnesses. Franz Alexander believes that a person who is genetically endocrine in certain organs and has specific psychological conflicts, when the stress of life provokes his psychological conflicts and he is no longer able to defend himself against them, will affect the disease of that organ.

But the cognitive theory of William Grace and David Graham believed that one's perception of the world and how he thinks about the threat, predicts what a psychiatric disorder will be. Certainly, cold-blooded women have a psychologically significant difference with those with a history of abortion and healthy. Anxiety and stress in their lives can cause mental illness and illness. Psychosocial factors can affect multiple physical conditions in a large number of organ systems such as respiratory system, cardiovascular system, skin and intestinal gut and sensory organs. These organs are more likely to be damaged in colds due to their conditions and their context for mental disorders, which can be due to the difference in the mental health of colds with healthy people with a history of abortion.

In relation to other research hypothesis, it was found that the average rate of women with a physical illness with a history of mental and physical disorders was different, as a result of the rate of sexual orientation of the samples in the three groups is not the same. Also, the results of post hoc test showed that there is a significant difference between the mean sexual tendency of people with a physical illness and healthy people with a history of mental disorders with respect to its significant level, but between mean sexual tendency among healthy people with a history of mental disorders There is no significant difference between the results of Yari-Zadeh (2014). When a person loses his ability to have sex, he has a negative impact on his life, including sexual failure, reduced self-esteem, feelings of inadequacy and insecurity. In addition, there are a lot of negative emotions. Compared to normal women, women suffering from this disease suffer from more negative emotions, including sadness, anxiety, frustration, frustration, helplessness and shame (Denerstain et al., 2008). Sexual desire is heavily influenced by the events of a person's life. When a person has a problem in some aspect of his life, he also indirectly affects his libido. Cold weather can occur for two main reasons. One of these reasons is a reduction in libido, and other reasons are psychological factors. In either case, the person loses his or her sexual desire either temporarily or permanently. In fact, colds are the same as not having sex with a partner without sexual desire. It is natural that cold-tempered people tend to have less sexual desire than healthy people with a history of abortion with normal sexual desire. Show themselves. But in healthy people with a history of abortion, this is different.

Healthy and abortive women experience normal and normal libido because of lack of sexual problems in their life, which can be the reason for the difference in libido between these individuals and colds.

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